Case Number:	CM13-0064630		
Date Assigned:	01/03/2014	**Date of Injury:**	03/15/2013
Decision Date:	03/20/2014	**UR Denial Date:**	11/27/2013
Priority:	Standard	**Application Received:**	12/12/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Anesthesiology, has a subspecialty in Pain Management, and is licensed to practice in Georgia. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The physician reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The claimant is a 53-year-old male presenting with neck pain following a work-related injury on March 15, 2013. The claimant reports sharp pain in the cervical region radiating to the right upper extremity. The physical exam was significant for weakness in the right wrist flexor and right extensor, and positive Spurling's test on the right. MRI of the cervical spine on April 10, 2013 was significant for C3-4 moderate right and mild left neuroforaminal stenosis, mild bilateral neuroforaminal stenosis at C4-5, mild bilateral neuroforaminal stenosis at C5-6, 6 mm disc protrusion causing moderate and potentially significant right neural foraminal stenosis at C6-7. The claimant has tried cervical epidural steroid injection, medial branch block, medications and activity modification. The cervical spine epidural steroid injection failed to reduce his pain. The cervical 4-6 medial branch block on November 2013 case is 50% reduction in pain.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

Right C3-4 and C6-7 posterior cervical foraminotomies: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 180.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 179-181.

Decision rationale: A right C3-4 and C6-7 posterior cervical foraminotomy is not medically necessary. According to the MTUS Guidelines, within the first three months of onset of potentially work-related acute neck and upper back symptoms, consider surgery only if the following are detected: Severe spinovertebral pathology; severe, debilitating symptoms with physiologic evidence of specific nerve root or spinal cord dysfunction corroborated on appropriate imaging studies that did not respond to conservative therapy. A disc herniation, characterized by protrusion of the central nucleus pulposus through a defect in the outer annulus fibrosis, may impinge on a nerve root, causing irritation, shoulder and arm symptoms, and nerve root dysfunction. The presence of a herniated cervical or upper thoracic disc on an imaging study, however, does not necessarily imply nerve root dysfunction. Studies of asymptomatic adults commonly demonstrate intervertebral disc herniations that apparently do not cause symptoms. Referral for surgical consultation is indicated for patients who have persistent, severe, and disabling shoulder or arm symptoms; activity limitation for more than one month or with extreme progression of symptoms; clear clinical, imaging, and electrophysiologic evidence, consistently indicating the same lesion that has been shown to benefit from surgical repair in both the short- and long-term; unresolved radicular symptoms after receiving conservative treatment. The efficacy of cervical fusion for patients with chronic cervical pain without instability has not been demonstrated. If surgery is a consideration, counseling and discussion regarding likely outcomes, risks and benefits, and especially expectations is essential. Patients with acute neck or upper back pain alone, without findings of serious conditions or significant nerve root compromise, rarely benefit from either surgical consultation or surgery. If there is no clear indication for surgery, referring the patient to a physical medicine and rehab (PM&R) specialist may help resolve symptoms. Based on extrapolating studies on low back pain, it also would be prudent to consider a psychological evaluation of the patient prior to referral for surgery. Many patients with strong clinical findings of nerve root dysfunction due to disc herniation recover activity tolerance within one month; there is no evidence that delaying surgery for this period worsens outcomes in patients without progressive neurologic findings. Spontaneous improvement in MRI documented cervical disc pathology has been demonstrated with a high rate of resolution. Surgery increases the likelihood that patients will have to have future procedures with higher complication rates. A 12% reoperation rate was reported in one large series. Patients with comorbid conditions, such as cardiac or respiratory disease, diabetes, or mental illness, may be poor candidates for surgery. Comorbidity can be judged and discussed carefully with the patient. The medical records did not provide electrophysiologic evidence of a lesion requiring surgical repair. Additionally the physical exam was not consistent with a lesion requiring surgery; therefore the requested surgery is not medically necessary.

Two (2) days stay: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Section Hospital Length of Stay.

Decision rationale: Request for 2 day stay is not medically necessary. According to the Official Disability Guidelines, surgical procedures involving discectomy/corpectomy without complications should have a one day stay for best practice target. Surgical procedures

involving laminectomy/laminotomy for decompression of spinal nerve root should have a one day stay for best practice target. If the employee were to have the requested surgical procedure without complications, best practice target would require a one day stay; therefore the requested is not medically necessary.

Assistant Surgeon: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American Association of Orthopedic Surgeons.

Decision rationale: The request for an assistant surgeon is not medically necessary. According to the American College of Surgeons, the first assistant to the surgeon during a surgical operation should be a trained individual capable of participating and actively assisting the surgeon to establish a good working team. The first assistant provides aid in exposure, hemostasis, and other technical functions, which will help the surgeon carry out a safe operation and optimal results for the patient. The role is varied considerably with the surgical operation, specialty area, and type of hospital. The the first assistant's role has traditionally been filled by a variety of individuals from diverse backgrounds. Practice privileges of those acting as first assistant should be based upon thorough 5 credentials reviewed and approved by the Hospital credentialing community. In general the more complex or risks of the operation the more high training the first Assistant should be. Criteria for evaluating the procedure including anticipated blood loss, anticipated anesthesia time, anticipated incidence of intraoperative complications, procedures requiring considerable judgmental or technical skills, anticipated fatigue factors affecting the surgeon and other members of the operating team, procedures requiring more than one operating team. In limb reattachment procedures at times save the use of 2 operating tissues is frequently critical to limb salvage. It should be noted that reduction and costly operating room time by the simultaneous work of two surgical teams can be cost effective. If the employee were to have the requested surgical procedure without complications, best practice target would not require an assistant surgeon. A surgical technician would be appropriate; therefore the request is not medically necessary.

Soft cervical orthosis: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Section Durable Medical Equipment (DME) Page(s): 89.

Decision rationale: A soft cervical orthosis is not medically necessary. The MTUS Guidelines do not specifically address this but under durable medical equipment, it indicates that cervical collars are not recommended for neck sprains. Patients diagnosed with whiplash associated disorders and other related acute neck disorders may commence normal, pre-injury

activities to facilitate recovery. Rest and immobilization using collars is less effective, and not recommended for treating whiplash patients. They may be appropriate where postoperative and fracture indications exist. Cervical collars are frequently used after surgical procedures and in the emergency setting following suspected trauma to the neck where it is essential that an appropriately sized brace preselected that properly fits the patient. If the employee were to have the surgical procedure, a soft cervical orthosis may be appropriate if there is indication for rest and immobilization. The request was not specific; therefore it is not medically necessary.